

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-013315

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3519

FILED APR 12 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. LouisLength of stay in 1b
1 day2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

c. CITY OR TOWN St. Louis

Inside Limits
Yes ☐ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Chronic Hosp.Inside Limits
Yes ☐ No ☐d. STREET ADDRESS (If outside, give location)
2830 S. JeffersonReside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First Stella

Middle Marie

Last Weil

4. DATE OF DEATH

Month Day Year
4-1-625. SEX
Female6. COLOR OR RACE
White7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday)
FEB 22 1895 67IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED LAUNDRY WORKER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
Mo.12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

James Watson

13b. MOTHER'S MAIDEN NAME

Catherine SCHNORRENBURG ARTHUR Weil (Doe'D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

HARRY WATSON 5451 HOLLY HILLS

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ACUTE PULMONARY EMBOLISM,

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

RIGHT FROM THROMBOSIS OF RIGHT

DUE TO (c)

FEMORAL VEIN

466x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Anticoagulant Heart DiseasePART III. If deceased was female was there a pregnancy in last 90 days.
☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐20a. ACCIDENT SUICIDE HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.
Month, Day, Year20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 3-30-62 to 4-1-62 and last saw her alive on 4-1-62
Death occurred at 7:25 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Deceased or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Removal APRIL 4, 1962

SUNSET BURIAL PARK

ST. Louis Co Mo

APR 3 1962

Earl Smith, M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Huron

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.